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BACKGROUND INFORMATION ON THE REIMBURSEMENT  
OF HOSPITALS' TEACHING EXPENSES

by

Jack Hadley



**THE URBAN INSTITUTE**  
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BACKGROUND INFORMATION ON THE REIMBURSEMENT OF  
HOSPITALS' TEACHING EXPENSES\*

I. INTRODUCTION

Containing rising hospital costs and altering the specialty distribution of physicians are two major health policy objectives. These goals overlap in considering the issues of paying teaching hospitals for patient care services and financing residency training programs. In both cases the reimbursement system should provide incentives for the efficient delivery of patient care in teaching hospitals and for the development of training programs consistent with public specialty distribution goals. Unfortunately, there are few analyses of the way reimbursement influences teaching programs and teaching expenses. Understanding the relationship is important for developing public policies which might use the reimbursement system to influence the specialty mix of residency programs or to encourage teaching hospitals to become more efficient in providing patient care. Accordingly, this paper has two purposes: (1) to summarize current information on the relative importance of various revenue sources for teaching hospitals; and (2) to describe variations in insurers' methods of paying for hospitals' teaching expenses.

At one level, the relationship between reimbursement and residency programs appears quite direct. The most visible expenses of residency programs are stipends paid to residents and salaries paid to physicians for educational activities. Indirect expenses include the costs of extra lab tests, X-rays, diagnostic procedures and hospital days which may be attributable solely to educational activities.<sup>1</sup> The major share of these expenses comes from funds generated by the delivery of patient care. Thus, if cost-containment measures

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should reduce hospitals' revenues or disallow certain costs earmarked as education expenses, what will be the impact on teaching programs, particularly on their size and specialty mix?

A hospital's patient care revenues, however, come from a variety of payment sources for care provided in different hospital settings: inpatient beds, emergency room, and clinics. This leads to a second, less visible facet of the relationship between reimbursement and teaching programs. Specialty services within a hospital generally vary in their revenue-generating capabilities because of variations in the settings where care is provided and in the nature of patients' insurance coverage in different settings. In addition, the method of reimbursement varies across settings and by type of insurance. These factors imply that even if a hospital's total revenue remains constant, changes in reimbursement methods by one type of payer or shifts in the relative importance of various third parties may influence the mix of residency programs offered.

A third concern raised by the multiplicity of payers and reimbursement methods is equity among patients in supporting teaching programs. The exact amount of subsidy provided to education programs by patient care revenues is unclear. Whatever the subsidy, however, it is not known whether the financial burden is borne evenly by different classes of insurers. If third parties pay different shares of teaching expenses, or pay nothing at all, then support of educational costs will be inequitably distributed.

Finally, Medicare and Medicaid together are the single largest source of hospitals' revenues. Nevertheless, it is important that these programs' payment policies and methods take account of how other payers reimburse



patient care services and teaching expenses. If Medicare and Medicaid should diverge sharply from other payers by adopting much more restrictive payment policies and/or much less generous payment levels, then their beneficiaries could experience considerably greater problems of access to private medical care providers. This suggests that efforts to alter Medicare and Medicaid policies toward teaching hospitals should be coordinated with private insurers' policies.

There are thus several reasons why it is important to have a better understanding of the relationship between reimbursement and graduate medical education programs: the impact of cost-containment policies on the size and specialty mix of residency programs; variations among specialties in the ability to generate patient care revenues; equity among patients in subsidizing graduate medical education; and consistency among Medicare, Medicaid, and private insurers in paying for both patient care and residency training.

The next section of this paper reports existing information on the relative importance of different payment sources to teaching hospitals in general. The paper's third section focuses on variations among payers in payment methods. The fourth section presents data on teaching expenses and sources of support. The final section draws tentative implications for the above issues and identifies information gaps and research needs.



## II. SOURCES OF SUPPORT FOR TEACHING HOSPITALS

Data on teaching hospitals' revenues and sources of support for teaching expenses are available from three sources: The Institute of Medicine's (IOM) 1975 study of teaching hospitals, The American Hospital Association's (AHA) 1978 Special Hospital Topics Survey, and the Council of Teaching Hospitals (COTH).<sup>2</sup> The IOM conducted a mail survey of all teaching hospitals in 1975 plus detailed, on-site data collection at 81 non-federal teaching hospitals.<sup>3</sup> Although the overall response rate for the mail survey was about 70 percent, the response rate for specific financial questions was frequently much lower. Nevertheless, this is the earliest set of financial data for a large number of teaching hospitals. The AHA's 1978 survey also experienced a modest response rate for its revenue questions, about 65 percent of teaching hospitals.<sup>4</sup> However, these data are more detailed than those available from the IOM study. Finally, COTH is the only source of time series data on teaching hospitals' finances.<sup>5</sup> However, its annual survey has never included more than 60 university-owned institutions. Although each of these sources has limitations, it is hoped that comparing data from the different surveys will indicate the accuracy and completeness of the available information.

The largest study of teaching hospitals' revenues and expenses was the Institute of Medicine's analysis of Medicare-Medicaid reimbursement. As noted above, the IOM study had two phases: a mailed survey of all teaching hospitals and in-depth site visits to a small sample of teaching hospitals. Table 1 reports data, collected from the mailed survey, on the distribution of revenues by major source. About 60 percent of the approximately one thousand nonfederal, allopathic teaching hospitals responded to the financial questions underlying Table 1. Data pertain to fiscal year 1974.





Both public (state and local) and private hospitals in both bed-size categories obtained between 36 and 40 percent of their total revenues from Medicare and Medicaid. Medicaid alone, however, was a much more important revenue source for public hospitals than for private hospitals. Public institutions were also much more dependent than private hospitals on nonpatient care revenues, which comprised about 18 percent of the total for the former compared to just over four percent for the latter. Conversely, private hospitals relied much more on revenue from private patient care sources (Blue Cross-Blue Shield, commercial insurance, and self-pay). Finally, differences in size, at least as defined here, seem to have minimal relationship to the distribution of revenues.

A more detailed breakdown of revenue sources is reported in Table 2, which presents data from 81 nonfederal hospitals in the site-visit portion of the IOM study. Separate percentages are presented by hospital ownership and medical school affiliation. These data indicate somewhat higher variation in the share of revenues from Medicare and Medicaid, although the overall patterns of Medicare, Medicaid, and other patient care sources is very similar to Table 1. Table 2 clearly shows the dependence of the state and local hospitals on government appropriations. (It should be noted that a large share of these appropriations are usually intended to help cover patient care expenses.) Private hospitals, on the other hand, received most of their nonpatient care revenue from gifts, endowments, investments, and research grants.

More recent data on a large number of teaching hospitals were obtained by the American Hospital Association in their 1978 survey of all short-term, nonfederal general hospitals. Table 3 reports percentage distributions of revenue sources by size, ownership, and teaching status.<sup>6</sup> Like the data in Table 1, these figures indicate that public teaching hospitals received more



than 20 percent of their funds from nonpatient care (primarily government) sources. This is a much higher proportion than reported by any other grouping of institutions. Among private hospitals, teaching institutions obtained about twice as much revenue from nonpatient care sources as nonteaching hospitals. However, these funds amounted to only about 6 or 7 percent of private teaching hospitals' revenues. Private teaching and all nonteaching hospitals relied on private patient care sources for more than half of their revenues. Public teaching hospitals received less revenue from Blue Cross and commercial insurers.

The only other source of data on the distribution of teaching hospitals' revenue is the Council of Teaching Hospitals. Unlike the previous two sources, the COTH survey has been conducted annually since 1971. Table 4 reports data for public and private institutions for various years.

Comparing the data for 1977 with those for the large (300+ beds) teaching hospitals in Table 3 reveals a roughly similar pattern. The largest differences occur in the Medicaid and Other Revenue categories. In particular, private hospitals in the COTH surveys receive about twice as much revenue from Medicaid as private teaching institutions in the AHA and IOM surveys. The greater importance of Blue Cross-Blue Shield to private institutions is similar in both Tables.

More interesting, however, are the trends revealed in Table 4. First, state appropriations have declined since 1973, from 21.7 percent of public hospitals' total revenues to 15.7 percent in 1977. Most of this drop has been taken up by increases in the shares of revenues from Medicare and commercial insurance. In fact, the latter was the second



largest revenue source for public institutions in 1977. Among private institutions, Blue Cross-Blue Shield was the second largest revenue source after Medicare.

COTH is also the only source of data on revenue sources by type of care (inpatient and outpatient). Table 5 reports data for 1973, 1976, and 1977. Medicare, Blue Cross, and commercial insurance have been the three most important sources of revenue for inpatient care, accounting for 70 percent of total inpatient revenue in 1977. In contrast, Self-Pay and Medicaid are the two largest sources of outpatient revenues. These data show that trends in Medicare and state appropriations revealed in Table 4 have occurred in both inpatient and outpatient settings. On the outpatient side, however, Commercial Insurance has grown steadily while State Appropriations and Other Revenues have declined by an offsetting amount. Finally, outpatient services are more than twice as dependent as inpatient services on revenues from nonpatient care services. Differences in revenue sources between inpatient and outpatient settings are of interest because of alleged difficulties in financing primary care residency training, which tends to take place in outpatient settings more frequently than does nonprimary care training.

Based on the data from these surveys, it appears that Medicare and Medicaid account for between 40 and 45 percent of revenues in both public and private institutions. Medicare is the larger of the two programs, particularly in private institutions. Revenues from other patient care sources make up about 50 percent of private hospitals' funds, but only between 35 and 40 percent of institutions' revenues. The difference is made up largely by government grants and appropriations, although the importance of this source appears to have declined steadily since 1973. Finally, outpatient



services receive much more of their funds from Medicaid, self-pay, and nonpatient care sources than do inpatient services.





### III. REIMBURSEMENT POLICIES FOR HOSPITALS' TEACHING EXPENSES

The previous section identified Medicare, Medicaid, Blue Cross, and commercial insurance as the primary third-party sources of hospitals' revenues. This section describes each insurer's policies on reimbursement of teaching expenses. In general, hospitals are paid on the basis of either costs or charges. Both approaches, however, face the same two generic problems: (1) how are costs (or charges) determined, i.e., which costs are "reasonable," and (2) how are costs (or charges) allocated among different insurers. All insurers pay for physicians' services on a fee or charge basis.<sup>7</sup> Insurers differ, though, in the level of payments made and in the method of determining the fee paid.

#### A. Hospital Reimbursement

Medicare, 39 Medicaid programs, and 36 Blue Cross plans reimburse hospitals on the basis of reasonable costs. The general distribution for determining reasonable costs is the American Hospital Association's Financial Requirements of Health Care Institutions and Services.<sup>8</sup> In particular, the net cost of education, defined as the "direct and general service cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs) less any reimbursement from grants, tuition and donations received from educational purposes," is an allowable item for the purpose of reasonable cost reimbursement.<sup>9</sup>

Medicare and Medicaid currently permit only one method of determining the share of reasonable costs which can be allocated to their beneficiaries.<sup>10</sup> Known as the departmental ratio of charges to charges applied to costs (DRCCAC) method, this approach requires the hospital to compute for each of its departments the ratio of charges for program beneficiaries to charges for all



patients. This fraction is then applied to the department's cost to obtain the share which is paid by Medicare and Medicaid. Ten Medicaid programs have federal approval to diverge from Medicare procedures in determining reasonable costs.<sup>11</sup> One requirement imposed on these plans is that the reimbursement method actually used not result in payments greater than would have been made using the Medicare formula. Little is known about the specific treatment of educational expenses. New York attempted to disallow ten percent of residents' stipends on the grounds that this represented pure education not related to patient care. This policy has since been overturned by the courts.<sup>12</sup>

A number of states also have a variety of rate setting or prospective reimbursement systems for paying hospitals. According to one source, there are more than 35 such experiments under way.<sup>13</sup> Again very little is known about the specific treatment of educational expenses. Since policies may vary widely under different plans, it is not possible to make any generalizations about the impact of rate setting on graduate medical education. Not surprisingly, there is little consistency in the findings of the few empirical studies which have investigated the implications for educational activities.<sup>14</sup>

Contracts between Blue Cross plans and participating hospitals are negotiated separately in each plan area. (See the Appendix for a listing of plans and plan characteristics.) As noted above 36, or 50 percent of the plans pay reasonable costs, which include net educational expenses.<sup>15</sup> Of these plans, 22 compute costs on the basis of average per diem and 14 use variations of the RCC (Ratio of Charges to Charges) method.<sup>16</sup> In addition, 4 plans exclude both Medicare and Medicaid patients from cost computations, while another 10 exclude Medicare patients only.<sup>17</sup> If Medicare and Medicaid patients are responsible for a disproportionate share of hospital costs, then "carrying-out" reduces the share of costs paid by Blue Cross.



The other 36 Blue Cross plans pay hospitals' charges, with 24 paying 100 percent of charges, 9 paying between 94 and 99 percent of charges, and the remaining 3 using some other approach.<sup>18</sup> In practice, however, differences among the charge- and cost-based plans may be minimal. First, plans and hospitals frequently negotiate charges so that they are pegged to costs, usually within a few percentage points of actual costs. Second, most of the cost-based plans impose a ceiling on payments, usually full charges or some fraction of charges.<sup>19</sup>

The fourth major source of third-party revenue is payments from patients covered by commercial insurance companies. It is difficult to characterize the structure of commercial health insurance because of the large number of available policies. Some information can be gleaned from surveys of group policies, which covered about 80 percent of the more than 110 million people with commercial health insurance coverage in 1976.<sup>20</sup> These plans almost always indemnify the policy holder, who in turn is responsible for paying the hospital's full charges. Although the combination of basic hospital plus major-medical coverage approaches complete insurance protection, many if not most policies are still subject to a variety of exclusions and/or limits on benefits, including coinsurance and deductibles for services covered by the major-medical portion.<sup>21</sup>

Table 6 reports various characteristics of 3,312 group policies written in the first quarter of 1978 and changes in benefits between 1973 and 1978. Section A indicates that only 38.2 percent of employees had either supplementary or comprehensive major medical insurance. Section B illustrates the types of limits and exclusions applied to these policies and their prevalence. Finally, Section C compares various characteristics of these policies in 1973



and 1978. There has been a clear trend toward more complete and more generous coverage. It should also be noted, though, that individual policies tend to be less comprehensive than group policies.

Self-pay patients make up the residual source of a hospital's patient care revenues. Like most commercial insurance policy holders, they pay for care on the basis of the hospital's charges for specific services used. It has been argued that charges to self-pay and commercially insured patients are established so that the hospital can meet its revenue requirements after accounting for revenues from other third-party sources. In effect, these patients bear the burden of supporting costs not allowed or not covered by other sources. Since net educational expenses are considered allowable costs, any inequities among payers in supporting education are the result of distortions in the formulas used to allocate costs (or charges) among insurers.

Although most hospitals receive the majority of their revenues from insurers who pay their share of net educational expenses, hospitals' charges nevertheless play a key role in determining how costs are allocated among insurers. In addition, charges to self-pay and commercially insured patients seem also to be used as mechanism for recovering costs disallowed or not covered by third-parties. Should insurers change existing policies and move toward disallowing some or all education expenses, then more of the burden of providing training revenues will fall upon revenues from charge paying patients. If bad debts and other collection problems are more prevalent for these patients, then all training programs, particularly those centered in outpatient settings, will probably experience financing difficulties.





## B. Physician Reimbursement

Except for certain hospital-based specialties, services provided by physicians to patients are reimbursed on a fee-for-service basis.<sup>23</sup> Insurers differ, however, in their methods of determining the fee actually paid. The two most common approaches are the usual-customary-reasonable (UCR) method and the fixed fee or fee schedule method.<sup>24</sup> Even under the former, however, there may be wide variations in payments made by different insurers because of differences in the formula used to calculate the reasonable fee.<sup>25</sup> Fee schedules or schedules of maximum payments have in the past been both less generous and less frequently updated than UCR payments. However, the most recent HCFA survey of physicians suggests that this may be changing: commercial insurers' schedules are slightly more generous than the "best" Blue Shield plan in the physician's area.<sup>26</sup>

Since almost all insurers pay on a fee rather than a cost basis, two factors determine the implications for educational program financing: (1) the level of fee payments, and (2) any regulations which might disallow payments to teaching physicians. With regard to the former, it is now well known that Medicaid generally pays the least for a given service and Blue Shield and commercial insurance the most, with Medicare in between.<sup>27</sup> Actual revenues, however, depend on the providers' ability to collect coinsurance, deductibles, and amounts charged in excess of the primary insurer's payment. Although there are no data on this, it seems likely that collection rates are highest for patients with private insurance (including policies which supplement Medicare).<sup>28</sup> It is also well known that payments tend to be more generous and private insurance coverage more extensive for services provided in an inpatient rather than an outpatient or clinic setting. Again, these



factors imply that training programs which tend to focus more on outpatient than inpatient care will have a relatively more difficult time generating revenues from patient care services.

The second issue in reimbursement of services provided by teaching physicians is determining when fees for such services are eligible for reimbursement. The study by the Institute of Medicine indicated that insurers differ in their documentation requirements for services provided by teaching physicians.<sup>29</sup> It seems obvious that a minimum requirement is that an identifiable service be provided. Much less clearcut, however, are questions of who is a teaching physician, what is education as opposed to patient care, and what is a private patient and/or personal physician relationship? Medicare's current guidelines are contained in Intermediary Letter 372 which states that in order to qualify for a professional fee, a teaching physician must:

- (1) review the patient's history and record of examinations and tests in the institution and make frequent reviews of the patient's progress;
- (2) personally examine the patient;
- (3) confirm or revise the diagnosis and determine the course of treatment to be followed;
- (4) either perform the physician's services required by the patient or supervise the treatment to assure that appropriate services are provided by interns, residents or others and that the care meets a proper quality level;
- (5) be present and ready to perform any service normally provided by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician," his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint;
- (6) be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the hospital stay.<sup>30</sup>



New and more restrictive regulations have been proposed under Section 227 of the 1972 Amendments to the Social Security Act. Because of the controversy and ambiguity inherent in trying to resolve by regulation the grey areas noted above, Section 227 has yet to be implemented. Very little is known about specific policies used by Medicaid programs or private insurers.

Analysis of this issue is clearly beyond the scope of this paper. If however, insurers' regulation make it more difficult for teaching physicians to receive professional fees, then it is likely that residency programs will find it more difficult to finance their costs. While any number of adjustments are possible, it also seems likely that programs which have the greatest difficulty generating revenues will be the first to experience cutbacks.



## IV. TEACHING PROGRAMS' EXPENSES, SOURCES OF SUPPORT, AND TIME ALLOCATIONS

The preceding two sections have described teaching hospitals' revenue sources and insurers' reimbursement practices. In order to help assess their implications for graduate medical education financing, this section reports some data on the costs of education programs, revenue sources allocated to these programs, and their distribution among various hospital settings. Before presenting these data, however, two important caveats must be raised. First, the education costs reported refer only to hospitals' direct expenses for residents' stipends and teaching physicians' salaries. This omits indirect expenses due to possible increases in the use of tests and other diagnostic procedures or in average length of stay, and opportunity costs, or the value of services foregone by the applications of both residents' and teaching physicians' time to pure education activities.<sup>31</sup> Second, the issues of the actual and normative distribution of these expenses are not addressed.<sup>32</sup>

Data collected by the Institute of Medicine indicate that salaries for residents and physicians comprised between 5 and 11 percent of hospitals' expenses. (See Table 7.) The figures for physicians' salaries may overstate expenses for teaching, since physicians may also receive salaries for administration, research activities, or pure patient care. The Council of Teaching Hospitals estimated compensation for house staff and teaching faculty to be 7.75 percent of the total net expenses of university-owned hospitals.<sup>33</sup> Crude extrapolation of these figures suggests a total national salary cost of about \$1.5 billion.<sup>34</sup>





Table 8 reports data on the distribution of funding sources used to support house staff stipends. Data from COTH and IOM refer to all residency programs in the hospitals sampled. Revenues from patient services (including physicians' fees) accounted for 77 and 79.8 percent of salaries in both two surveys respectively. However, the COTH hospitals received almost three times as much money from government sources as did the IOM hospitals. These differences are most likely due to the different samples and time periods covered.

Finally, the Institute of Medicine also collected data on the importance of funding in determining the size of residency programs and the distribution of residents' time among different patient care settings in the hospital. Table 9 summarizes these data, ranking programs by the proportion of time residents spent in outpatient settings. Although the numbers of programs are fairly small, family practice and psychiatry were both most dependent on funding factors and had the largest share of their time in outpatient settings. Medical, pediatric, and surgical specialties spend about the same amount of time in outpatient care, but surgical programs cited funding considerations only about half as frequently. This is probably attributable to surgical residents spending twenty-five percent of their inpatient time in surgery, compared to less than one percent for the medical and pediatric specialties. Finally, the hospital based specialties of radiology, pathology, and anesthesiology reported the least amount of outpatient time and relatively less concern about funding constraints.

Overall, the direct costs of graduate medical education, salaries paid to house staff and faculty, appear to comprise almost ten percent of teaching hospitals' expenses. In the aggregate, this amounts to an annual expenditure of approximately \$1.5 billion. Data on funding sources for house staff salaries indicate that about 80 percent comes from patient care revenues. This suggests



that education programs are disproportionately dependent on nonpatient care funds, since on average, patient care services generate more than 90 percent of hospitals' total revenues. (This figure is lower for public hospitals, but higher for private institutions, see table 3.) Finally, there are distinct variations across specialties in the allocation of house officer time among different patient care settings and the importance of funding considerations in determining house staff complements.



## V. SUMMARY

The relationship between reimbursement and graduate medical education is an important, but not well understood factor germane to several current policy issues: containing rising hospital costs, influencing the specialty distribution of physicians, and achieving equity in paying for both medical care and graduate medical education. This paper has summarized existing data on the importance of different revenue sources to teaching hospitals, on third-party payers' policies on reimbursing educational expenses, and on the costs and time allocations of residency programs. Although this information is too fragmented and insufficiently detailed to draw firm conclusions, it does serve as a useful backdrop for future analyses.

Several data bases revealed that Medicare and Medicaid are teaching hospitals' most important revenue sources, accounting for over forty percent of total revenues. Medicaid, however, appears to be a much more important source for public hospitals than for private hospitals. In addition, public hospitals derive about 20 percent of their revenue from nonpatient care sources, primarily government appropriations. This compares to about 5 percent for private hospitals. Blue Cross-Blue Shield revenues, on the other hand, are a much more important source of private hospitals' revenues. Finally, inpatient and outpatient services differ markedly in their dependence on various revenue sources: Medicare and Blue Cross are the two largest sources of inpatient revenue, while self-pay and Medicaid are most important on the outpatient side.

Medicare and Medicaid currently recognize net educational expenses as reimbursable costs. Information on cost-based Blue Cross plans' policies on net educational expenses is not readily available. However, if these



plans follow the AHA's recommendations in Financial Requirements of Health Institutions, then they too reimburse net educational expenses. Although charge-based Blue Cross plans do not pay costs, the apparently close relationship between negotiated charge payments and costs implies that these insurers also recognize education as a reimbursable expense. Again, there is little readily available information on any disallowances or exclusions of net educational expenses by individual plans. Patients covered by commercial insurance or without insurance are generally expected to pay the hospitals' charges. Since all of the major third-party insurers recognize net educational expenses as reimbursable costs, there would not appear to be any direct inequities in the burden of supporting residency programs. Indirect distortions may exist, however, if charges are manipulated so that different payers (including self-pay patients) do not in fact bear the true economic cost of the services used by their beneficiaries. There is no direct evidence on this issue.

Insurers differ in the generosity of fees paid to physicians and in regulations governing the circumstances under which teaching physicians are permitted to submit bills for professional fees. The one study which investigated this issue found Medicare's regulations (I.L.-372) sufficiently complex and teaching physicians' compensation and billing arrangements sufficiently varied that no firm conclusions could be drawn. Much less is known about Medicaid, Blue Shield, and commercial insurance policies in this area.

Total expenditures for house staff and faculty salaries were estimated to be about \$1.5 billion in 1977, with house staff salaries comprising just over 80 percent. Data on revenue sources used to pay residents' salaries





indicate that about 80 percent comes from patient care revenues. Since teaching hospitals on average obtain more than 90 percent of their revenues from patient care sources, this suggests that funding for residency programs is disproportionately dependent on nonpatient care sources. Comparisons across specialties also suggest that residency programs in primary care specialties are more sensitive to funding constraints than either surgical or hospital-based specialties. Residents in the primary care specialties also tend to spend the greatest proportion of time in outpatient settings.



TABLE 1

Distribution of Revenue Sources, by Ownership  
and Bed Size, Fiscal 1974  
(IOM Mail Survey Hospitals)

<u>Revenue Source</u>	<u>Public</u> <sup>1</sup>		<u>Private</u>	
	<u>100-300 Beds</u>	<u>300+ Beds</u>	<u>100-300 Beds</u>	<u>300+ Beds</u>
Medicare	17.2%	17.5%	25.3%	27.9%
Medicaid	22.1	19.3	11.7	9.5
Other Patient Care	42.5	45.3	58.6	58.2
Other Revenue	18.2	17.9	4.4	4.3
(Sample Size)	(76)	(96)	(114)	(315)

Note: 1. Excludes federal hospitals

Source: Institute of Medicine, unpublished data



TABLE 2

Distribution of Revenue Sources, by Medical  
School Affiliation and Ownership, Fiscal 1974  
(IOM Site Visit Hospitals)

Revenue Source	State	Principal		Graduate associated		Undergrad. assoc.	Independent
		Local	Private	Local	Private	Private	Private
Patient care	65%	74%	88%	63%	88%	87%	90%
Medicare	(14)	(16)	(22)	(15)	(29)	(26)	(25)
Medicaid	(14)	(23)	(13)	(24)	(8)	(15)	(18)
Other payors	(37)	(35)	(53)	(25)	(50)	(47)	(48)
State or local government appropriations	30	26	0	30	1	1	<u>a/</u>
Medical school transfer	<u>a/</u>	0	1	<u>a/</u>	<u>a/</u>	<u>a/</u>	0
Gifts, investments, and endowments	1	<u>b/</u>	4	1	7	5	3
Other <u>b/</u>	4	<u>b/</u>	6	6	4	7	7

Note: Figures are based on patient care charges before adjustments for such items as bad debts and discounts to staff. The majority of hospitals did not allocate adjustments among payors. Excluded are VA hospitals which are funded wholly by the federal government and children's hospitals which receive Medicare reimbursement for renal dialysis unit costs only. Totals may not add to 100 percent due to rounding.

a/ Less than 0.5 percent

b/ Includes revenues from research grants, government contracts, and auxiliary enterprises.

Source: Institute of Medicine, Medicare-Medicaid Reimbursement Policies, 1976, p. 98.



TABLE 3  
Distribution of Revenue Sources, by Teaching Status, Ownership,  
and Bed Size, 1978  
(AHA Survey)

Revenue Source	Teaching Hospitals				Nonteaching Hospitals				Total
	Public		Private		Public		Private		
	100-300 Beds	300+ Beds	100-300 Beds	300+ Beds	100-300 Beds	300+ Beds	100-300 Beds	300+ Beds	
Medicare	22.5%	22.8%	28.9%	32.2%	33.9%	33.7%	35.3%	33.7%	31.8
Medicaid	19.8	22.0	12.7	9.4	8.4	4.7	8.1	6.1	10.3
Other Patient Care	30.4	34.2	50.9	50.8	53.0	58.0	53.5	57.3	51.3
(BC-BSI/)	(9.3)	(11.2)	(23.8)	(24.4)	(17.1)	(12.4)	(20.7)	(20.8)	(21.0)
(Commercial Ins.)	(10.0)	(12.6)	(15.5)	(12.6)	(21.3)	(20.6)	(17.0)	(19.7)	(16.0)
(Other2/)	(11.1)	(10.4)	(11.6)	(13.8)	(14.6)	(25.0)	(15.8)	(16.8)	(14.3)
State - Local Govt.	7.4	7.3	1.5	0.9	1.1	0.6	0.5	0.8	1.6
Govt. Grants 3/	14.8	7.7	1.1	0.7	1.2	0.3	0.2	0.1	1.5
Other Federal	0.6	0.9	1.6	0.3	0.2	0.1	0.3	0.1	0.4
Other Revenue	4.4	5.1	3.6	3.4	2.1	3.4	2.0	1.9	3.0
(Sample Size)	(41)	(85)	(142)	(388)	(231)	(21)	(766)	(186)	(1860)

Notes: 1. Blue Cross-Blue Shield  
2. Includes self-pay, charity, and other patient revenue  
3. Government grants, subsidies for patient care  
4. Other revenue from all sources

Source: American Hospital Association, unpublished data.





TABLE 4

Distribution of Revenue Sources, by Ownership,  
Fiscal Years 1977, 1976, and 1973  
(COTH Survey)

	1977		1976		1973	
	Public	Private	Public	Private	Public	Private
Medicare	19.6%	27.1%	19.8%	25.8%	12.3%	20.1%
Medicaid	15.4	14.7	16.2	14.2	14.5	16.6
Other Patient Care	39.3	50.3	35.3	52.1	38.2	52.9
Blue Cross	(13.8)	(23.3)	(15.6)	(24.9)	(15.9)	(26.2)
Commerical	(18.2)	(16.2)	(14.9)	(14.7)	(14.9)	(16.8)
Self Pay	(7.3)	(10.8)	(4.8)	(12.5)	(7.4)	(9.9)
State Appropriation	15.7	2.4	17.8	2.7	21.7	2.5
Other Government <u>1/</u>	1.0	0.6	0.8	0.1	2.5	0.3
Other <u>2/</u>	9.0	4.9	10.1	5.1	9.8	7.6
(Sample Size)	(42)	(20)	(43)	(18)	(28)	(15)

- Notes: 1. Includes county and city appropriations.  
2. Includes additional welfare payments, government contracts for patient care, workman's compensation, overhead from sponsored research, and other revenues

Source: Council of Teaching Hospitals, COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data, 1979, 1978, and 1975, Table 5.

Key: "Principal" teaching hospitals are those in which the medical school clinical departments direct all aspects of all the graduate training programs in the hospitals. Thirty-two of the sample hospitals are principal teaching hospitals.

"Graduate associated" teaching hospitals are the sites of training programs directed by medical school clinical departments and may additionally have training programs independent of the medical school. Forty-four of the sample hospitals are graduate associated teaching hospitals.

"Undergraduate associated" teaching hospitals are involved with medical schools only for undergraduate clinical training and carry out independent graduate medical education programs. Ten of the sample hospitals are in this category.

"Independent" teaching hospitals conduct their own graduate medical education programs. Ten of the sample hospitals are independent hospitals.



TABLE 5

Distribution of Revenue Sources, by  
Type of Care, Fiscal Years 1977, 1976 and 1973  
(COTH Survey)

	1977		1976		1973	
	<u>OUTP</u>	<u>INP</u>	<u>OUTP</u>	<u>INP</u>	<u>OUTP</u>	<u>INP</u>
Medicare	16.8%	27.2%	14.2%	25.9%	8.6%	16.8%
Medicaid	18.2	17.1	17.1	17.0	19.8	15.1
Other Patient Care	49.5	50.0	46.7	46.8	42.7	45.9
Blue Cross	(10.0)	(22.1)	(8.8)	(22.1)	(11.4)	(21.4)
Commercial Ins.	(17.3)	(20.0)	(13.2)	(17.7)	(9.4)	(18.0)
Self Pay	(22.2)	(7.9)	(24.7)	(7.0)	(21.9)	(6.5)
State Appropriation	4.6	2.1	8.9	4.8	14.2	12.5
Other Government <u>1/</u>	2.2	0.3	0.4	0.0	2.9	1.0
Other <u>2/</u>	8.7	3.3	12.7	5.3	11.7	8.7
Sample Size)	(57)		(52)		(43)	

- Notes: 1. Includes county and city appropriations  
2. Includes additional welfare payments, government contracts for patient care, workman's compensation, overhead from sponsored research, and other revenues

Source: Council of Teaching Hospitals, COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data, 1979, 1978, and 1975, Table 5.



TABLE 6

Various Characteristics of Commercial Health  
Insurance Policies, 1978 and 1973

## A. Extent of Coverage, 1978

Type of Coverage	Percentage of Employees	
	All Employees Surveyed (463,373)	Groups of 25-499 Employees (114,039)
Basic.....	42.2%	31.4%
Hospital.....	39.4	29.7
Surgical.....	29.5	29.1
Regular medical.....	27.5	24.8
In-hospital.....	27.4	24.6
In-office.....	13.7	4.0
In-home.....	13.8	4.2
Diagnostic X-ray and laboratory.....	26.5	25.2
Dental.....	31.2	18.8
Supplementary major medical.....	17.5	36.3
Comprehensive major medical.....	20.7	48.0
Nursing home.....	24.7	58.6
Short-term disability.....	21.8	27.7
Long-term disability.....	28.0	6.4

B. Plan Characteristics, 1978 (Percentage of Employees with Each Type of Benefit;  
by Type of Coverage)

Type of Coverage	Total Covered	% of Covered with Benefit
Basic Hospital Expense Coverage	182,315	
• full coverage for semiprivate room		78%
• daily room and board benefit of at least \$100		89%
• unlimited coverage of misc. expenses		74%
• intensive care coverage		46%
• pre-admission testing coverage		...



TABLE 6 (continued)

## C. Comparison of 1973 and 1978 Policies, Groups of 25-499 Employees

1. Maximum Hospital Daily Room and Board Benefits and Periods for Which They Will Be Paid

Maximum Daily Benefits	Percentage of Employees	
	1973	1978
Less than \$30.....	8.2%	1.3%
\$30-39.....	13.2	0.7
\$40-49.....	22.4	0.2
\$50 or more.....	32.4	22.5
Full payment-- semiprivate.....	23.8	73.2
Full payment--ward.....	--	2.1
Maximum Number of Days		
Under 70.....	39.7%	19.2%
70-99.....	25.3	17.4
100-179.....	18.8	26.2
180 days and over.....	11.3	29.7
No limit on number of days, but limit on total amount payable.....	4.9	7.5

2. Maximum Surgical Benefit

Maximum Surgical Benefit	Percentage of Employees	
	1973	1978
Less than \$600.....	33.4%	7.0%
\$600-799.....	9.2	4.8
\$800-999.....	9.1	7.4
\$1,000 or more.....	45.1	52.8
Reasonable and customary.....	3.2	28.0

3. Maximum Major Medical Benefit

Maximum Major Medical Benefit	Percentage of Employees	
	1973	1978
\$5,000.....	1.7%	--
\$10,000.....	7.5	1.9%
\$15,000.....	4.8	0.6
\$20,000.....	9.5	1.9
\$25,000.....	14.8	1.7
\$25,001-49,999.....	9.1	--
\$50,000.....	21.6	2.8
\$50,001-99,999.....	1.8	--
\$100,000.....	5.0	2.6
More than \$100,000.....	24.2	88.5

\* Includes policies with no limit on benefit

Source: New Group Health Insurance (Health Insurance Institute, Washington, D.C.: 1979).





TABLE 7

Distribution of Expenditures, by Medical  
School Affiliation and Ownership, Fiscal 1974  
(IOM Site Visit Hospitals)

Expenditure Category	Principal			Graduate associated		Undergrad. associated	Indepen- dent
	State	Local	Private	Local	Private	Private	Private
Total salaries	64%	54%	52%	56%	56%	58%	59%
Physicians	(4)	(6)	(2)	(5)	(2)	(6)	(6)
House officers	(6)	(5)	(3)	(5)	(3)	(4)	(4)
Other personnel	(55)	(43)	(47)	(46)	(51)	(49)	(49)
Contracted services	1	0	1	2	3	1	2
Transfer to medical school	1	0	5	1	1	1	0
All other expenditures	34	46	42	41	40	41	38

Source: Institute of Medicine, Medicare-Medicaid Reimbursement Policies, 1976, p. 99.

Key: "Principal" teaching hospitals are those in which the medical school clinical departments direct all aspects of all the graduate training programs in the hospitals. Thirty-two of the sample hospitals are principal teaching hospitals.

"Graduate associated" teaching hospitals are the sites of training programs directed by medical school clinical departments and may additionally have training programs independent of the medical school. Forty-four of the same hospitals are graduate associated teaching hospitals.

"Undergraduate associated" teaching hospitals are involved with medical schools only for undergraduate clinical training and carry out independent graduate medical education programs. Ten of the sample hospitals are in this category.

"Independent" teaching hospitals conduct their own graduate medical education programs. Ten of the sample hospitals are independent hospitals.



TABLE 8

Distribution of Funding Sources for Support of Intern  
and Resident Stipends

<u>Source of Funds</u>	<u>COTH</u>	<u>IOM</u>
Patient Revenue/General Operations	75%	79.1%
Physician Fees	2	.7
Medical school/university funds	2	6.2
State Appropriations	5	$\left. \begin{array}{l} \\ \\ \\ \end{array} \right\} 5.2 \frac{1}{2}$
Municipal Appropriations	7	
NIH	1	
Other Federal Agencies	1	
Endowment/Foundations/Voluntary Agencies	1	.5
Other	8	8.4
(Sample Size)	(252)	(81)

Note: 1. All government funds combined

Sources: A. Checker, COTH Survey of House Staff Policy and Related Information, 1977, p. 38; and G. Yoder and J. Brady, "Graduate Medical Education Costs and Sources of Support," in Institute of Medicine, "Graduate Medical Education in the United States," 1978, Table 2.



TABLE 9

Residents' Time Distribution and the Importance  
of Funding Factors, by Specialty, 1975

Specialty	Distribution of Patient Care Time by Setting				Funds Cited as Factor in Establishing Program Size		
	No. of Respondents <sup>1/</sup>	Outp. <sup>2/</sup>	Imp. <sup>3/</sup>	Lab & X-Ray	Total Programs	Funds Cited	Percent
Psychiatry	379	45.6%	53.4%	1.1%	19	15	73.7
Family Practice	128	34.9	64.2	0.9	10	6	60.0
Gen. Pediatrics	360	26.7	72.7	0.5	109 <sup>5/</sup>	67	61.5
Med. & Ped. Subspecialties	637	25.6	65.7	8.7			
Surgery	1202	25.2	72.8	2.2	155	49	31.6
Int. Medicine	917	22.2	75.7	2.0	88	39	44.3
Ob. Gyn.	325	19.7	79.0	2.3			
Radiology	280	9.8	16.7	73.5			
Pathology	253	3.7	23.9	72.3			
Anesthesiology	198	2.4	96.5	1.0			
All	4865 <sup>4/</sup>	23.3	69.1	7.6	388 <sup>6/</sup>	184	47.4

- Notes: 1. Respondents are individual house officers at 96 site visit hospitals.  
 2. Includes emergency room.  
 3. Includes special care units and operating room.  
 4. Includes 276 residents in other specialties.  
 5. Includes internal medicine.  
 6. Includes 7 programs in other specialties.

Source: Distribution of effort data are from W. Chao and E. Curran, "A Description of House Office Effort," in Institute of Medicine, "Graduate Medical Education in the United States," 1978, Table 4; funds data are from Institute of Medicine, Medicare-Medicaid Reimbursement Policies, 1976, p. 161.



FOOTNOTES

1. The full costs of graduate medical education include the cost of changes in treatment (extra tests, additional hospital days) due purely to education, indirect costs associated with overhead, fringe benefits, etc., direct expenditures for materials and supplies used in educational activities, and the opportunity cost (value of foregone time) attributable to residents and teaching physicians. For more complete discussions of the definition of full costs and its measurement, see R. Feldman and S. Yoder, "A Theoretical Analysis of Graduate Medical Education Financing," in J. Hadley, ed., Medical Education Financing: Policy Analyses and Options for the 1980s (New York: Prodist, 1980) and S. Yoder, "Methods for Determining the Cost of Graduate Medical Education," in Division of Health Manpower and Resource Development, "Graduate Medical Education in the United States," Institute of Medicine, National Academy of Sciences, mimeo, 1978.
2. Additional data for internal medicine programs are available in A. Tarlov et al., "National Study of Internal Medicine Manpower: Residency Training 1976-1977," Annals of Internal Medicine 88 (March 1978):413-20.
3. Institute of Medicine, National Academy of Sciences, Medicaid-Medicare Reimbursement Policies (Washington, D.C.: U.S. Government Printing Office, 1976) and "Graduate Medical Education in the United States," op. cit. A teaching hospital is defined as any hospital which trains interns or residents.
4. American Hospital Association, "Special Survey on Selected Hospital Topics," September 1978. Teaching hospitals are defined as hospitals with at least one approved residency training program.
5. Council of Teaching Hospitals, Association of American Medical Colleges, "COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data," April 1979 and earlier years.
6. It should be noted that teaching status in Table 3 is based on the presence of at least one AMA-approved residency program. This is a more restrictive criterion than the one used by IOM.
7. Prepaid group practices or other institutions which provide physicians' services on a contractual basis and physicians in the so-called hospital-based specialties are exceptions. However, these exceptions probably have little interaction with graduate medical education.





FOOTNOTES (Cont'd.)

8. See H. Berman and L. Weeks, The Financial Management of Hospitals (Ann Arbor, Michigan: Health Administration Press, 1979), p. 175.
9. Commerce Clearing House, Medicare-Medicaid Guide (New York: Commerce Clearing House, Inc., 1974), p. 1761.
10. Berman and Weeks, pp. 180-81.
11. Medicare/Medicaid Management Institute, Health Care Financing Administration, USDHEW, Data on the Medicaid Program: Eligibility Services, Expenditures (Baltimore, Maryland: Health Care Financing Administration, 1979), pp. 21-2.
12. R. Knapp and P. Butler, "Financing Graduate Medical Education," New England Journal of Medicine 301 (October 4, 1979), p. 750.
13. Berman and Weeks, p. 142.
14. F. Sloan, "Patient Care Reimbursement: Implications for Medical Education and Physician Distribution," in J. Hadley, ed., Medical Education Financing, op. cit.
15. F. Liddell, "Blue Cross Contract Provisions as of June 30, 1976," Division of Financial Management, American Hospital Association, mimeo, January 1977, p. 3.
16. Ibid., p. 4.
17. Ibid.
18. Ibid., p. 3.
19. Ibid., Table 2.
20. M. Carroll, "Private Health Insurance Plans in 1976: An Evaluation," Social Security Bulletin 41 (September 1978), p. 4; and New Group Health Insurance (Health Insurance Institute, Washington, D.C.: 1979).
21. Ibid., p. 7.
22. Berman and Weeks, pp. 198-9.
23. For a discussion of reimbursement of hospital-based specialists, see B. Steinwald, "Hospital-Based Physicians: Current Issues and Descriptive Evidence," Institute of Public Policy Studies, Vanderbilt University, mimeo, June 1979; Arthur Andersen and Co., Study of Reimbursement and Practice Arrangements of Provider-Based Physicians. Final Report to the Health Care Financing Administration, December, 1977.



FOOTNOTES (Cont.d)

24. The customary-prevailing-reasonable method used by Medicare is essentially identical to UCR except for differences in terminology.
25. For more information, see J. Showstack et al., "Fee-for-Service Physician Payment: Analysis of Current Methods and Their Development," Inquiry XVI (Fall 1979):230-246.
26. Personal communication from Frank Sloan based on analysis of unpublished HCFA data.
27. F. Sloan, "Patient Care Reimbursement," op. cit.
28. For indirect evidence, see Sloan, Cromwell and Mitchell, Private Physicians and Public Programs (Lexington, Mass.: Lexington Books, 1978) p. 97.
29. Cited in Knapp and Butler, "Financing Graduate Medical Education," pp. 752-3.
30. Ibid., p. 752.
31. See Yoder, "Determining the Cost of Graduate Medical Education," and Feldman and Yoder, "A Theoretical Analysis of Graduate Medical Education Financing," op. cit.
32. For discussion of the who-should-pay issue, see M. Fruen, "Issues in Who Should Pay for Graduate Medical Education," National Center for Health Services Research, mimeo, October 1979.
33. Council of Teaching Hospitals, "COTH Survey of University Owned Teaching Hospitals' Financial Data," April 1979, pp. 30, 39, 40. The 7.75 percent figure was derived by taking the ratio of the sum of clinical faculty physician compensation and house staff stipends and other costs to total net expenses.
34. The COTH data show that the ratio of salaries for faculty teaching time to house officers' salaries is .187. Fruen has estimated total expenditures for house staff salaries of about \$1.3 billion. Multiplying this figure by 1.187 results in the estimate of about \$1.5 billion. See M. Fruen, "An Overview of the Medical Education System and Its Financing," in J. Hadley, ed., Medical Education Financing, op. cit.



## Appendix

## Blue Cross Plans--Payment Characteristics, 1976\*\*

TABLE 2 -- METHODS OF PAYMENT

PLAN	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros	Reim. % of Chge.	Supportive Info or Prior Approval	Notice of Increase Days	Apportionment of Cost	Carve Out	Ceiling/Limit on Payment
AL, Birmingham		x	No				APD	No	No
AZ, Phoenix	x		No	100	BC, State rate review	30			
AR, Little R.	x		No	100	BC	30			
CA, Los Angel.		x	No				APD	Yes MEC MED option	Yes/Chges.
CA, Oakland	x		No	100	BC	30			
CO, Denver		x	No				CRCC	No	No
CT, New Haven		x	Yes* BNR/ cost				APD	No	Yes/Chges.
DE, Wilmington	x		Yes BNR/ chge.	100	BC	30			
DC, Washington		x	Yes BNR/ chge.				APD	No	No
FL, Jacksonville	x		Yes other* chge.	100	BC	60			
GA, Atlanta	x		Yes BNR/ chge.	100	BC	60			

ABBREVIATIONS: FTR-Formula Target Rate (Cost-based), BNR-Budget Negotiated Rate, BC-Blue Cross, SRSA-Standard Rate Setting Authority, APD-Average per diem, CRCC-Combination RCC, DRCC-Departmental RCC, MEC-Carve out of Medicare patient costs prior to apportioning cost, MED-Carve out of Medicaid patient cost prior to apportioning cost, IA-Carve out of industrial accident cases prior to apportioning cost, NA-Non Applicable, NS-Not specified.

\*Appendix A

\*\* Source: American Hospital Association, "Resurvey of Hospital--Blue Cross Contract Provisions," January 1977.



TABLE 2 -- METHODS OF PAYMENT (continued)

State	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros.	Reim. % of Chge.	Supportive info or Prior Approval	Notice of Increase (Days)	Apportion- ment of Cost	Carve Out	Ceiling/ Limit on Payment
GA, Columbus	x		Yes ENR/ chge.	100	BC	Mutually agreed upon			
ID, Boise	x		Yes other* chge.	100	BC	90			
IL, Chicago		x	No				APD	No	Yes/105% of per diem in oper. cost
IL, Rockford	x		No	75-100	No	NS			
IN, Indianapo.	x		Yes*	100	BC	90			
IA, Des Moines		x	No				CRCC, DRCC	Yes MED, MEC	Yes/chges.
SD, Sioux City		x	No				APD	Yes MEC	No
KS,** Topeka		x					APD	No	Yes/other Lower of cost or chges.
	x		Yes ENR/ chge.	100	BC	60			
KY, Louisville	x		Yes ENR/ chge.	100	BC	90			
LA, Baton Rouge	x		Yes ENR/ chge.	100	BC	30, 60, 90			
ME, Portland		x	No				DRCC	Yes MEC	Yes/chges.

Appendix A.

\*\*Appendix B.





TABLE 2 — METHODS OF PAYMENT (continued)

PLAN	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros.	Reim. % of chge.	Supportive info or Prior Approval	Notice of Increase, Days	Apportionment of Cost	Carve Out	Ceiling/Limit on Payment
MD, Baltimore	x		Yes chges/HSCRC*	94	SRSA	NA			
MA, Boston		x	No				CRCC	No	Yes/chges. & lower of cost or chge.
MI,** - Detroit									
MN,* St. Paul <sup>1</sup>	x		No	97	No	NS			
		x					APD	Yes MEC	Yes/chges.
MS,* Jackson	x	x	No				APD	Yes	Yes/chges. other cost +13%
Kansas City	x		Yes BNR/chge.	100	BC	90			
MO,* St. Louis		x	Yes/FTR				APD for Standard Benefits	Yes MED, MEC	Yes/75-80%* chges.
MT,* <sup>2</sup> Great Falls (2 options)	x		Yes Rate review Approv chge.	100	Rate Review System	30			
		x					APD plus 6%	Yes MEC	Yes/chges.
NE, Omaha	x		No	98	No	30 (room rate inc.)			
NH/VT** Concord (2 options)	x		Only chge. based	97	BC	30			
		x					APD	No	Yes/lower of cost or chg.

\*Appendix A

\*\*Appendix B



TABLE 2 -- METHODS OF PAYMENT (continued)

PLAN	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros.	Reim. % of chge.	Supportive info or Prior Approval	Notice of Increase, Days	Apportionment of Cost	Carve Out	Ceiling/Limit on Payment
NJ, Newark		x	No				APD	Yes MEC	No
NM, Albuquerque	x		No	100	BC	60 by con. 30 actual usage			
NY, Albany		x	Yes FTR				APD	No	Yes/chges.
NY, New York		x	Yes FTR				APD	No	Yes/chges.
NC, Durham	x		Yes ENR/chge.	100	BC	30			
ND, Fargo	x		Yes*	100	No	NS			
( Canton		x	No				CRCC, DRCC	No	No
OH, Cincinnati	x		Yes	100	BC	90			
OH, Cleveland		x	No				APD	Yes MEC	Other*
OH, Columbus		x	No				APD	No	Yes/chges.
OH, Lima		x	No				DRCC	No	Yes/97% of chges.
OH, Toledo		x	No				APD	Yes MEC	Yes/97% of chges.
OH, Youngstown		x	No				APD	Yes MEC	Yes/other*
OK,** Tulsa	x		Yes ENR chge.	100	No	30			

\*Appendix A.

\*\*Appendix B.



TABLE 2 -- METHODS OF PAYMENT (continued)

PLAN	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros.	Reim. % of chge.	Supportive info or Prior approval	Notice of Increase, Days	Apportionment of Cost	Carve Out	Ceiling/ Limit on Payment
OK, Tulsa (cont'd.)		x	No				only total cost & rev. are compared	No	Yes/changes.
OR, Portland	x		No	100	BC	30			
PA, Allentown		x	No				DRCC	No	Yes/100% of chge.
PA, Harrisburg		x	No				DRCC	No	Yes/100% of chge.
PA, Pittsburg		x	Yes other/cost*				Gross RCC	Yes MEC	Yes/110% wtd. group APD
PA,** Philadel.		x	Yes other*				DRCC	No	Yes/other
PA, Wilkes-Barre		x	No				Non-Medicare per diem	Yes MEC	Yes/98% of chge.
RI,** Providence		x	Yes BNR/cost				DRCC	No	Yes/other*
	x		No	NS	Other*	NS			
SC, Columbia	x		No	100	BC	30			
TN, Chattanooga	x		No	98	BC	60			
TN, Memphis	x		No	97	No	NS			
TX, Dallas	x		Yes chge/NEG billed chges.	100	BC	60			

\*Appendix A.

\*\*Appendix B.



TABLE 2--METHODS OF PAYMENT (continued)

PLAN	Contract Payment			Charge Based			Cost Based		
	Chge.	Cost	Pros.	Reim. % of chge.	Supportive Info or Prior to Approval	Notice of Increase, Days	Apportionment of Cost	Carve Out	Ceiling/Limit on Payment
UT, Salt Lake City	x		No	100	BC	30			
VA, Richmond		x	No				APD	NS	Yes/chges. % of increase over pr. yr. pay. rate
VA, Roanoke		x	No				APD	NS	Yes
WA/AK, Seattle		x	No				CRCC	No	Yes/chges.
WV, Bluefield	x		Yes other*	97	BC	15			
WV, Charleston	x		No	95	BC	30			
W, Wheeling		x	No				DRCC	Yes	Yes/not to exceed 115% of cost
WI, **3 Milwaukee	x		Yes/BNR	97	BC	90	APD	Yes MEC MED	No
WY, Cheyenne	x		No	100	BC	Prior to increase.			

<sup>1</sup>Hospitals with less than 2500 Blue Cross patient days are under charged-based contract. (Minnesota)

<sup>2</sup>Hospitals participating in rate review program are under charge-based contract. (Montana)

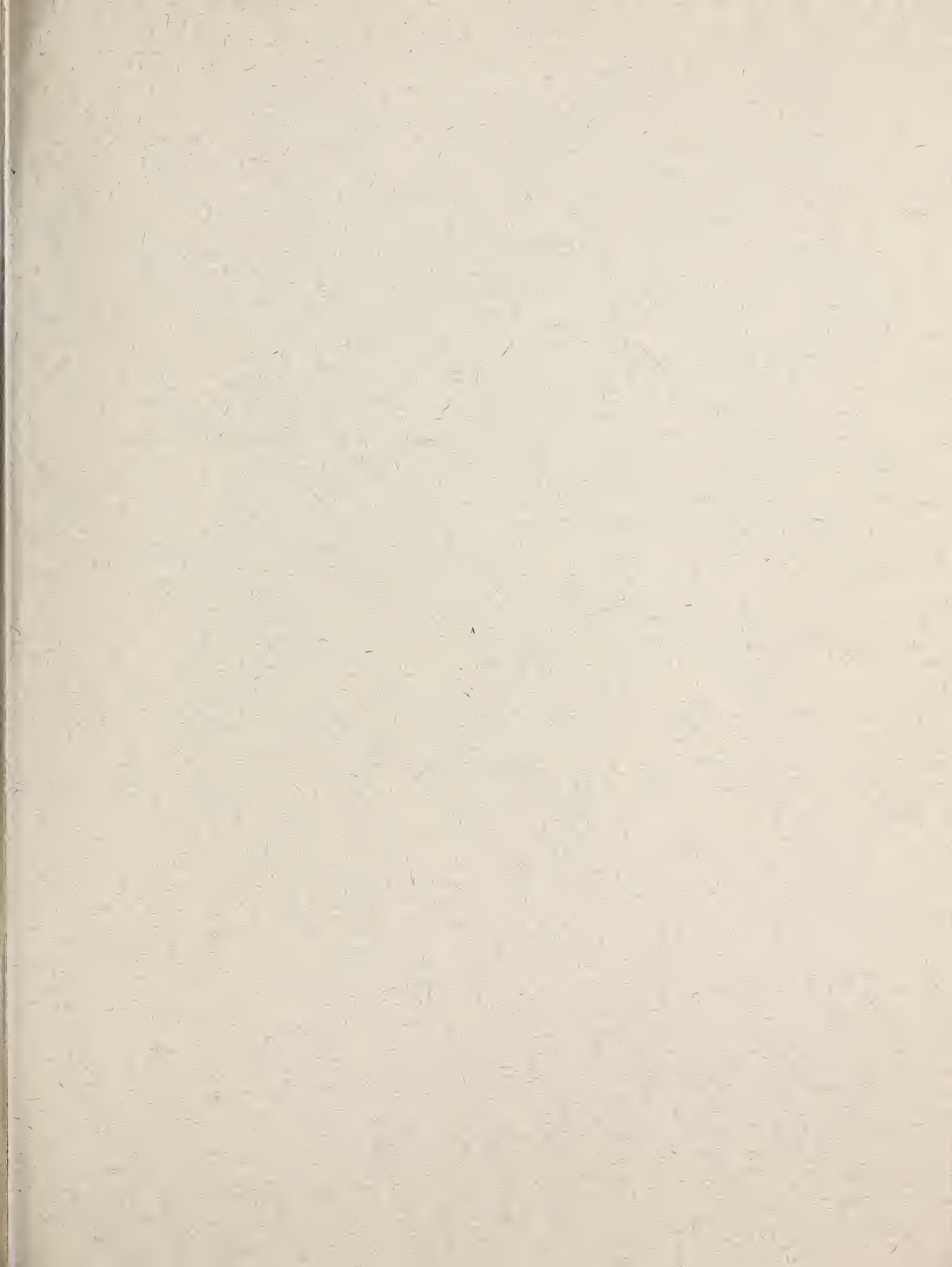
The information recorded under cost based for Wisconsin are considered financial requirements.

\*Appendix A.

\*\*Appendix B.







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